Memorial PRIMARY CARE | URBANA

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can obtain access to information. Please review carefully.

OUR LEGAL DUTY: Memorial Medical Group d/b/a Memorial Primary Care | Urbana, is required, by law to protect the privacy of your Personal Health Information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION: Memorial Medical Group d/b/a Memorial Primary Care | Urbana will use your Personal Health Information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Memorial Medical Group d/b/a Memorial Primary Care | Urbana may use your Personal Health Information to contact you to provide appointment reminders, or information about treatment alternatives or other related benefits that could be of interest to you.

Memorial Medical Group d/b/a Memorial Primary Care | Urbana may also use or disclose your Personal Health Information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situation, Memorial Medical Group d/b/a Memorial Primary Care | Urbana policy is to obtain your written authorization before disclosing your Personal Health Information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Memorial Medical Group d/b/a Memorial Primary Care | Urbana may change its policy at any time. When changes are made a new NOTICE OF INFORMATION PRACTICES will be posted in a common area of all offices. You may also request an updated copy of our NOTICE OF INFORMATION PRACTICES at any time.

PATIENT'S INDIVIDUAL RIGHTS: You have the right to review or obtain a copy of your Personal Health Information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You have the right to request a list of instances where we have disclosed your Personal Health Information for reasons other than treatment, payment, or other related administrative purposes.

You may request in writing that we not use or disclose your Personal Health Information for treatment, payment and/or administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Memorial Medical Group d/b/a Memorial Primary Care | Urbana will consider all such requests on a case-by-case basis, but Memorial Medical Group d/b/a Memorial Primary Care | Urbana is not legally required to accept them.

CONCERNS AND COMPLAINTS: If you are concerned that Memorial Medical Group d/b/a Memorial Primary Care | Urbana may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your Personal Health Information, please contact our HIPAA Compliance Office at the address and phone number listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Memorial Medical Group d/b/a Memorial Primary Care | Urbana Health Information Practices, or if you have a complaint, please contact the following office:

HIPAA Compliance Office
Memorial Medical Group d/b/a
Memorial Primary Care | Urbana
500 London Avenue, Marysville, OH 43040

NOTIFICATION TO ALL PATIENTS

The rigid regulations of the insurance industry require us to have you sign the following release.

PLEASE READ THEM ALL CAREFULLY

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf, however, if my insurance company denies payment for any reason (i.e. non-covered services, does not pay for preventive medical visits, failure to secure a referral from my primary care physician, etc.) I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is for the purpose of this agreement constitutes a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

Insurance Release: I hereby assign all medical benefits to which I am entitled to Memorial Medical Group d/b/a Memorial Primary Care | Urbana in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

Consent to Treatment: I do hereby consent to such treatment, by the authorized personnel of Memorial Medical Group d/b/a Memorial Primary Care | Urbana as may be dictated by prudent medical practice, of my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Responsible Party Signature: X_____Date: _____

HIPAA Receipt Confirmation:

I have received a copy of Memorial Medical Group d/b/a Memorial Primary Care | Urbana Notice of Patient Information Practices.

Responsible Party Signature: X_____Date: _____

Office personnel ONLY: ☐ Attempted & Refused: _____

Memorial Primary Care | Urbana
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name:

Patient's Date of Birth: Patient's SSN:

A. Person(s) or Organization(s) authorized to provide the information:

B. Person(s) or Organization(s) authorized to receive the information:

C. Specific description of the information that may be used or disclosed (including date(s))

D. Specific description of how the information will be used:

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1) I understand that this authorization will **expire** on *(insert date)*.
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying *Memorial Primary Care | Urbana, Inc.* in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_X_____ _____
Patient's Signature or Patient's Representative Date

X_____ _____
Printed Name of Patient's Representative Relationship to Patient

NOTE:
You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").*
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*
You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM